

§ 156.470 Allocation of rates for advance payments of the premium tax credit.

(a) *Allocation to additional health benefits for QHPs.* An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each health plan at any level of coverage offered, or intended to be offered, in the individual market on an Exchange, an allocation of the rate for the plan to:

(1) EHB, other than services described in § 156.280(d)(1); and

(2) Any other services or benefits offered by the health plan not described in paragraph (a)(1) of this section.

(b) *Allocation to additional health benefits for stand-alone dental plans.* An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each stand-alone dental plan offered, or intended to be offered, in the individual market on the Exchange, a dollar allocation of the expected premium for the plan, to:

(1) The pediatric dental essential health benefit, and

(2) Any benefits offered by the stand-alone dental plan that are not the pediatric dental essential health benefit.

(c) *Allocation standards for QHPs.* The issuer must ensure that the allocation described in paragraph (a) of this section—

(1) Is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies;

(2) Reasonably reflects the allocation of the expected allowed claims costs attributable to EHB (excluding those services described in § 156.280(d)(1));

(3) Is consistent with the allocation applicable to State-required benefits to be submitted by the issuer under § 155.170(c) of this subchapter, and the allocation requirements described in § 156.280(e)(4) for certain services; and

(4) Is calculated under the fair health insurance premium standards described at 45 CFR 147.102, the single risk pool standards described at 45 CFR 156.80, and the same premium rate standards described at 45 CFR 156.255.

(d) *Allocation standards for stand-alone dental plans.* The issuer must ensure that the dollar allocation described in

paragraph (b) of this section is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies.

(e) *Disclosure of attribution and allocation methods.* An issuer of a health plan at any level of coverage or a stand-alone dental plan offered, or intended to be offered, in the individual market on the Exchange must submit to the Exchange annually for approval, an actuarial memorandum, in the manner and timeframe specified by HHS, with a detailed description of the methods and specific bases used to perform the allocations set forth in paragraphs (a) and (b), and demonstrating that the allocations meet the standards set forth in paragraphs (c) and (d) of this section, respectively.

(f) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must submit the allocations and actuarial memorandum described in this section to the U.S. Office of Personnel Management, in the time and manner established by the U.S. Office of Personnel Management.

[78 FR 15535, Mar. 11, 2013, as amended at 79 FR 13840, Mar. 11, 2014]

§ 156.480 Oversight of the administration of the cost-sharing reductions and advance payments of the premium tax credit programs.

(a) *Maintenance of records.* An issuer that offers a QHP in the individual market through a State Exchange must adhere to, and ensure that any relevant delegated entities and downstream entities adhere to, the standards set forth in § 156.705 concerning maintenance of documents and records, whether paper, electronic, or in other media, by issuers offering QHPs in a Federally-facilitated Exchange, in connection with cost-sharing reductions and advance payments of the premium tax credit.

(b) *Annual reporting requirements.* For each benefit year, an issuer that offers a QHP in the individual market through an Exchange must report to HHS, in the manner and timeframe required by HHS, summary statistics specified by HHS with respect to administration of cost-sharing reduction and advance payments of the premium

§ 156.500

tax credit programs, including any failure to adhere to the standards set forth under § 156.410(a) through (d), § 156.425(a) through (b), and § 156.460(a) through (c) of this Part.

(c) *Audits.* HHS or its designee may audit an issuer that offers a QHP in the individual market through an Exchange to assess compliance with the requirements of this subpart.

[78 FR 65100, Oct. 30, 2013]

Subpart F—Consumer Operated and Oriented Plan Program

§ 156.500 Basis and scope.

This subpart implements section 1322 of the Affordable Care Act by establishing the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of new consumer-governed, private, nonprofit health insurance issuers, known as “CO-OPs.” Under this program, loans are awarded to encourage the development of CO-OPs. Applicants that meet the eligibility standards of the CO-OP program may apply to receive loans to help fund start-up costs and meet the solvency requirements of States in which the applicant seeks to be licensed to issue CO-OP qualified health plans. This subpart sets forth the eligibility and governance requirements for the CO-OP program, CO-OP standards, and the terms for loans awarded under the CO-OP program.

§ 156.505 Definitions.

The following definitions apply to this subpart:

Applicant means an entity eligible to apply for a loan described in § 156.520 of this subpart.

Consumer operated and oriented plan (CO-OP) means a loan recipient that satisfies the standards in section 1322(c) of the Affordable Care Act and § 156.515 of this subpart within the timeframes specified in this subpart.

CO-OP qualified health plan means a health plan that has in effect a certification that it meets the standards described in subpart C of this part, except that the plan can be deemed certified by CMS or an entity designated by CMS as described in § 156.520(e).

45 CFR Subtitle A (10–1–14 Edition)

Exchange has the meaning given to the term in § 155.20 of this subchapter.

Formation board means the initial board of directors of the applicant or loan recipient before it has begun accepting enrollment and had an election by the members of the organization to the board of directors.

Individual market has the meaning given to the term in § 155.20 of this subchapter.

Issuer has the meaning given to the term in § 155.20 of this subchapter.

Member means an individual covered under health insurance policies issued by a loan recipient.

Nonprofit member organization or *nonprofit member corporation* means a nonprofit, not-for-profit, public benefit, or similar membership entity organized as appropriate under State law.

Operational board means the board of directors elected by the members of the loan recipient after it has begun accepting enrollment.

Predecessor, with respect to a new entity, means any entity that participates in a merger, consolidation, purchase or acquisition of property or stock, corporate separation, or other similar business transaction that results in the formation of the new entity.

Pre-existing issuer means a health insurance issuer that was in existence on July 16, 2009.

Qualified nonprofit health insurance issuer means an entity that satisfies or can reasonably be expected to satisfy the standards in section 1322(c) of the Affordable Care Act and § 156.515 of this subpart within the time frames specified in this subpart, until such time as CMS determines the entity does not satisfy or cannot reasonably be expected to satisfy these standards.

Related entity means an entity that shares common ownership, control, or governance structure (including management team or Board members) with a pre-existing issuer, and satisfies at least one of the following conditions:

(1) Retains responsibilities for the services to be provided by the issuer.

(2) Furnishes services to the issuer's enrollees under an oral or written agreement.

(3) Performs some of the issuer's management functions under contract or delegation.